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EDITORIALS

Drastic Therapies

The use of somatic treatment procedures in psychiatry is nothing new. Blood letting, purgatives and emetics, vaccines, endocrinological substances, fever production with malaria and typhoid, prolonged narcosis with sedatives, and surgical procedures like thyroidectomy and hysterectomy—all these have been utilized in the past. And they were considered as drastic as the methods now being widely used, such as insulin and the various electro-convulsive treatments. The term "shock" therapy is a misnomer. Physiological shock is not produced, and the treatment is not directed at frightening or "shocking" the symptoms out of the patients. To describe these methods, including the surgical approach known as frontal leukotomy, as "drastic therapies" may be accurate in that they are violent treatments which may act rapidly and dramatically. But this is not to their discredit, for psychotherapy itself may be even more violent in its onslaught on the psychological defenses of the individual.

The shock therapies—insulin, electro-shock and electronarcosis—are now being re-evaluated and revised in the light of long continued experience. There is overwhelming evidence that convulsive therapy materially shortens the majority of depressive episodes, in particular those severe depressions observed during the involutional period. The therapeutic effect is not so certain nor so dramatic in the manic attack. Such treatment is definitely not prophylactic, and it will not prevent recurrence.

The results of the electro-convulsive treatment of schizophrenia are not so certain. Dramatic results may be obtained in selected cases, but relapses are definitely more frequent than in the affective psychoses. Although it was first thought that the newer electronarcosis treatment of schizophrenia might offer better results than electro-shock therapy, continuing clinical experience does not confirm this first impression. It is probable that electronarcosis offers little advantage over electro-shock, and that the therapeutic efficacy of each mode of treatment depends essentially on the production of a convulsion. In the treatment of the psychoneuroses, electro-convulsive therapy has been for the most part a failure, and too often it has been administered because the therapist has been frustrated in his psychotherapeutic efforts or because he has rationalized to himself that the patient will be more psychotherapeutically accessible if the "affective" components of the patient's illness are removed by the convulsive therapy. Since the patients in such cases usually do not need hospital care, many have been treated in office practice, sometimes indiscriminately and without the supervision needed in the period immediately following treatment. However, the therapy in general should not be condemned because it has been injudiciously applied in some cases. It has definite limitations, as does every other therapy in medicine. It is not a panacea. It is not without certain hazards and possible complications, such as vertebral fractures, which can be adequately controlled by appropriate measures in competent hands. Within these limitations electro-convulsive therapy is a powerful and efficacious tool in the therapeutic armamentarium of the psychiatrist.

Because of its simplicity and ease of administration, electro-shock therapy has tended to supplant the more complicated insulin hypoglycemic treatment, although there is considerable evidence that insulin therapy is more beneficial in the treatment of schizophrenia. With any treatment the relapse rate is high, particularly in schizophrenia. Shock therapy in any form can be looked upon as only one facet of a total psychiatric regime, and it should be considered only after a thorough study of the patient has been made.

No adequate theory of the mechanism of action, physiological or psychological, of shock therapy has as yet been formulated. The theory of a biological antagonism between epilepsy and schizophrenia, advocated by von Meduna, has not been substantiated, nor do the theories emphasizing the importance of an anoxia of the brain or stimulation of the sympathetic nervous system in producing therapeutic results serve as entirely satisfactory explanations. Psychological theories to the effect that the treatment acts as a threat to life which mobilizes all the patient's energies to return to reality, or that it acts as a medium by which the patient expiates his sense of guilt, may sound intriguing, but it is seldom that facts can be found to substantiate them. No one of these concepts is sufficient in itself to explain adequately the speed with which therapeutically dramatic results occur.

Surgical operation for the relief of mental symptoms has been practiced since ancient times. Even today the removal of the uterus and ovaries, or of the thyroid, is too often done for the relief of "nervousness." The operation of frontal lobotomy or leukotomy is, however, a more direct approach to the problem of amelioration of the symptoms of mental disease, and it is advocated with the neurophysiological rationalization that isolation of the prefrontal cortex by cutting the fiber connections between the thalamus and prefrontal cortex will cause psychopathologic ideas and feelings to lose their emotional potency and that in time these may even disappear. The procedure is still in a stage of development at which it should be considered only for those patients who are believed to be chronically ill, who have not responded to other appropriate forms of therapy and who are not likely to recover in the future. These would include patients with chronic schizophrenia, chronic depressions, and long-standing severe obsessive compulsive symptoms which have not responded to psychotherapy and shock therapy and whose symptoms seriously interfere with the individual's social and occupational adjustment. Observation of patients who have undergone this operation leaves little doubt that destruction of areas considered to be the seat of the intellect can affect the personality greatly and the intellect very little. Defects do occur, especially at the level of imaginative and creative thinking, and although much of this loss is regained over a period of years, complete restitution is improbable. Apparently other association pathways take over the function of the cut fibers.

In making a decision about recommending frontal lobotomy for a patient, one must remember that one is introducing and superimposing an organic disease of the brain on a functional disorder. If that functional disorder is a chronic disabling or deteriorating one, and the symptoms resulting from leukotomy will be less handicapping than the functional disorder, therein lies the indication for operation if all other modes of therapy have failed. Any therapeutic means, limited though they may be, which can help to deal with the serious problems of mental disease, demand unbiased and unprejudiced appraisal. Each must be considered only as a part of a total psychiatric structure in which psychotherapy should be the cornerstone.

Industrial Medical Fees

Heartening news for the medical profession came out of the Industrial Accident Commission of the State of California last month, when the Commission approved a surgical fee in excess of the minimum fee set forth in the official schedule. If this action may be considered a test case, the medical profession may confidently expect fair and impartial consideration by this important state body.

In the case recently decided, a surgeon was called upon, just as he was leaving a hospital, to examine an injured patient who had just been brought in. The patient was a workman who had fallen from a scaffold and was in a dangerous condition. The surgeon ordered a blood transfusion, called for two other specialists, a surgeon and a urologist, and did an exploratory laparotomy. When he located the injury in a kidney, he performed a nephrectomy via transperitoneal approach, followed up with more transfusions, and complete recovery resulted. Here was a definite life-saving procedure, performed in emergency circumstances and resulting in a splendid recovery.

When the surgeon rendered his statement to the insurance carrier he was tendered a check for the minimum fee for nephrectomy, plus the attendant charges. He protested the small fee allowed, particularly in view of the difficulties and time consumed in the operation, only to be met with the statement that the fee schedule adopted by the Industrial Accident Commission set forth that particular fee for that particular procedure. On the advice of the California Medical Association and with its cooperation, the doctor filed a claim for the fee he had requested. A hearing was held by a referee and the Industrial Accident Commission granted the doctor the fee he had asked.

One of the startling aspects of this case was the claim of the medical director of the insurance carrier that the California Medical Association had been instrumental in drawing up the existing industrial